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UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY

Report of UNICEF/WHO Joint Committee on Health Policy on its special session held at WHO headquarters

Geneva, 27-28 January 1994

The Executive Director recommends that the Executive Board note the present report and endorse the recommendations contained in paragraphs 27, 30, 32, 34, 36, 43, 50, 54, 59, 62, 65, 68, 72-73, 79 and 80.

World Health Organization
Organisation mondiale de la santé

United Nations Children's Fund
Fonds des Nations Unies pour l'enfance

UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY JCHPSS/94.4
Special session
Geneva, 27-28 January 1994 7 March 1994

REPORT OF THE UNICEF/WHO JOINT COMMITTEE ON HEALTH POLICY ON ITS SPECIAL SESSION

WHO headquarters, Geneva
27-28 January 1994

CONTENTS

Page

I. INTRODUCTION 3

II. SUMMARY OF STATEMENTS BY THE DIRECTOR-GENERAL OF WHO AND THE EXECUTIVE DIRECTOR OF UNICEF 3

III. WORLD SUMMIT FOR CHILDREN 5

Follow-up action 5
Review of progress 6
(i) Expanded Programme on Immunization 6
(ii) Neonatal tetanus 7
(iii) Measles deaths and cases 8
(iv) Poliomyelitis-free status 8
(v) Oral rehydration therapy/diarrhoea case management 9
(vi) "Baby-friendly" hospitals 9
(vii) Guinea-worm transmission (dracunculiasis) 11
(viii) Water supply and sanitation 11
(ix) Iodine deficiency disorders 13
(x) Vitamin A deficiency 13
(xi) Reduction of protein-energy malnutrition 14
(xii) Knowledge of HIV/AIDS-related preventive practices 14

IV. WORLD SUMMIT FOR CHILDREN - HEALTH INDICATORS AND THE MONITORING PROCESS 15

V. PLACE AND DATE OF THE THIRTIETH SESSION 17

VI. CONCLUDING REMARKS 17

ANNEX 1. Agenda 18

ANNEX 2. List of participants 19

I. INTRODUCTION

1. Dr Y. Kawaguchi, Director, Division of Interagency Affairs, WHO, opened the session and welcomed participants.

2. Dr Meropi Violaki-Paraskeva, Vice-Chairman of the WHO Executive Board, was unanimously elected Chairman. Dr M. A. A. Al-Sakkaff (Yemen), member of the UNICEF Executive Board, and Dr K. Al-Jaber (Qatar), member of the WHO Executive Board, were elected Rapporteurs.

3. The Chairman recalled that the terms of reference of the Joint Committee - the longest-standing interagency committee in the United Nations system - included review of the overall health needs of mothers and children, examination of progress and assessment reports on different types of jointly assisted health activities, and recommendations for appropriate action. It was urgent to alleviate the burden of ill-health carried by women and children in developing countries, particularly in Africa. Despite progress made in reducing infant, child and maternal mortality, there were still 4.2 million newborn children dying each year, and in some countries maternal mortality rates were from 200 to 500 per hundred thousand live births. It was urgent to join forces in seeking new and more effective ways to achieve complementary action at country, regional and global levels. One of the Committee's tasks was to assist both organizations to define clearly their respective responsibilities and modes of operation in order to recommend to national governments clear and realistic action with maximum impact.

4. She briefly outlined the work of the Committee at its previous session in February 1993, which had included recommendations concerning eight mid-decade goals, subsequently endorsed by the executive boards of both UNICEF and WHO, and to be discussed by the Committee at its present session. These mid-decade goals had been set to give clear focus and direction to achievement of the end-of-decade goals set by the World Summit for Children.

5. The agenda (document JCHPSS/94/1.1/Rev.2) was adopted and is attached as Annex 1. The list of participants is given in Annex 2.

II. SUMMARY OF STATEMENTS BY THE DIRECTOR-GENERAL OF WHO AND THE EXECUTIVE DIRECTOR OF UNICEF

6. Dr Hiroshi Nakajima, Director-General of WHO, said that the WHO Executive Board at its ninety-third session had devoted much attention to the implementation of reform in WHO with a view to enhancing the Organization's support and services to its Member States, and noted that the UNICEF Executive Board was also to undergo changes following decisions reached by the forty-eighth session of the General Assembly of the United Nations.

7. In a rapidly moving global environment, WHO had to face new health challenges brought about by the current epidemiological transition, aggravated by political, economic and social problems, and had consequently undertaken to review and adapt its policies, structures and working methods. There was also a need to foster greater involvement of "civil society" alongside government, mobilizing all actors in society in order to ensure the success of WHO's health-for-all policies through primary health care. That could be achieved through the new partnerships for health which WHO had been promoting for the past year.

8. Intersectoral and interagency cooperation within the United Nations system, particularly with UNICEF, was a high priority. The WHO Executive Board had adopted a series of resolutions on major health issues related to the present meeting, including the proposed establishment of a joint and cosponsored United Nations programme on HIV/AIDS to be administered by WHO. The Organization looked forward to the endorsement of the relevant study by the UNICEF Executive Board at its forthcoming session and expected much from UNICEF's support and active participation in that programme, notably in the field of health education, both in and out of school, to prevent the spread of HIV/AIDS and sexually transmitted diseases.

9. Cooperation had also been pursued in all fields relating to vaccines, from research and development to country operations, including immunization. WHO's Expanded Programme on Immunization, the

WHO/UNDP programme for vaccine development and the joint Children's Vaccine Initiative were being brought together in a consolidated programme.

10. The fact that global immunization coverage for children under one year of age was lower in 1992 than in 1990 made it essential to ensure an adequate supply of high-quality, low-cost vaccines, for which additional financial resources would be required. Mobilization of resources from donors and the participation of industry would be more effective if organizations worked in synergy, streamlining their vaccine-related policies and activities. In times of economic recession and escalating health costs, much remained to be done for women and children, who were often hardest hit by poverty and increasing unemployment. Worldwide life-expectancy at birth might have increased, but perinatal mortality rates among women and infants in many developing countries remained unacceptably high. One national study had shown that about 40% of maternal deaths could be attributed to wrong diagnosis or inappropriate case management. Furthermore, measles still caused an average of 1.13 million deaths annually in developing countries, and every year over 10 million children under five years of age died of the effects of poverty and underdevelopment. Faced with those figures, countries and the international community must reflect on their commitment to the health, welfare and dignity of all human beings. Solidarity was not only an ethical but a political choice, and must be based on equity and independence, with a view to achieving peace and sustainable development.

11. 1994, as the International Year of the Family, provided an opportunity to underscore the importance of the joint efforts of UNICEF and WHO to promote and protect the health and welfare of mothers and children. The Joint Committee remained a powerful means of coordinating and monitoring activities within the United Nations system in particular in support of children and women. Although the 1995 mid-decade goals might appear aspirational, particularly in countries with weak health infrastructures, they were technically feasible. They called for political will and solidarity, both at national and international levels, translated into tangible commitments and supported by effective public health planning and management.

12. WHO was consequently considering different options to accelerate the eradication or elimination of poliomyelitis, leprosy and dracunculiasis, despite the fact that some endemic countries, particularly in Africa, were going through serious political and economic difficulties. It was to be hoped that the Joint Committee, inspired by the long-standing partnership between UNICEF and WHO, would advise the secretariats of both WHO and UNICEF in their efforts to strengthen national capabilities and help countries achieve their self-appointed goals for 1995 and for the year 2000.

13. Mr J. Grant, Executive Director of UNICEF, commended WHO on its leadership and vision in the health-for-all programme. For over 45 years, UNICEF and WHO had shared the struggle, sometimes with conspicuous success, as with the eradication of yaws in the 1950s, sometimes less successfully, as in the case of malaria. Programmes such as those on essential drugs, nutrition and immunization were saving the lives of three million children per year. Disabilities due to poliomyelitis had been reduced from half a million to 140 000, and there was the prospect that before too many years they would be eliminated. Central to that collaboration was the role of members of the respective executive boards in the Joint Committee on Health Policy.

14. UNICEF would continue to maintain current levels of support for the global immunization programme throughout the remaining years of the decade. Full and strong partnership between WHO and UNICEF would permit the seizing of powerful opportunities to combat such scourges as measles and dehydration through diarrhoeal diseases. Such goals were a means of mobilizing not only the organizations themselves, but also nongovernmental organizations and governments, to achieve synergy. The mid-decade goals, which had been conceived by the World Health Assembly, were an important stepping-stone to the goals for the year 2000.

15. National efforts were a major and vital component of achieving such targets, although partnership with the external world was vital as a catalyst for action. He emphasized UNICEF's commitment to collaborate with WHO in areas where their work was complementary. WHO's strength was in setting goals and standards, while UNICEF had a strong field presence and experience in mobilizing funds and society in countries and globally.

16. As results in Mexico and the United Republic of Tanzania had shown, political commitment was a key factor in meeting targets. The decentralization of responsibility in many countries would serve the purposes of

the Organization's work. There was a need to strengthen monitoring, in order to ensure that progress was sustained and the lessons of experience drawn.

17. He drew attention to achievements in combating iodine and vitamin A deficiency diseases, and to progress in eradicating poliomyelitis. Recognizing that many of the goals were aspirational, such goals could be transformed into real targets and achieved. Success boosted confidence and morale within health systems, which made it possible to tackle other tasks for the goal of health for all by the year 2000. He attributed success in other areas of social progress to the confidence gained in tackling disease successfully. The key to real accomplishment was the will to achieve targets. Inspired leadership was one stimulus, but, as recent cholera epidemics in Peru and elsewhere had shown in necessitating the wider use of oral rehydration therapy, fear was also a powerful stimulus.

18. Lastly, he emphasized that opportunities implied the responsibility to act. There was a moral responsibility in failing to achieve major progress, where such progress was possible. The Health Assembly indicated where goals were achievable. The question was whether the world would respond.

III. WORLD SUMMIT FOR CHILDREN

Follow-up action

19. The background paper[1] contained a summary of progress towards the achievement of the goals for the health of women and children within national health systems by the year 2000, and areas where accelerated efforts were required. It also proposed specific action to be undertaken by JCHP.

20. The Committee discussed the need for a creative approach in setting goals while at the same time ensuring that they were realistically and technically achievable. Goals could inspire action, provided there was the appropriate political will, but the setting of unrealistic targets at country level might have the contrary effect. It was necessary to strike a balance. Countries needed a system as well as a goal, and health could not be separated from overall development.

21. There was broad agreement that health could not be divorced from other social factors. The key to promoting health was alleviation of poverty. The "basic minimum needs" approach to some of the root causes of disease, such as poor water supplies, food and shelter was effective. Besides resources and the necessary political will to achieve the goals for the year 2000, a vital element was community participation. By involving the community, a new tradition of local responsibility would be developed which would ensure that progress achieved in meeting the goals would be sustained thereafter. Successful examples of an integrated approach, involving such aspects as family planning, water, sanitation and the growing of suitable food crops were reported in Bangladesh and Somalia. A good example of a local community taking responsibility for its own affairs was the public vaccine fund which had been established in Benin.

22. The importance of preventing disease was stressed and it was agreed that, by and large, primary prevention could be achieved through education. A school health curriculum to promote healthy lifestyles had been adopted in many countries, particularly at primary-school level.

23. An important factor in reducing infant and maternal mortality and morbidity was the quality of health care. In many countries health care coverage was almost 100% but morbidity rates did not decline. The reason was that the quality of care was inadequate. Better training and supervision of health professionals was needed to address that situation. In particular, traditional school and university education, which focused on clinical aspects of medical training, should be adapted to reflect the needs of practical medicine in the community. Medical professionals should be trained to work at the primary health care level and to encourage prevention of disease.

24. Many examples of progress in immunization and prevention of iodine and vitamin A deficiencies were reported. In Africa, governments were actively promoting iodization of salt to combat iodine deficiency

[1] Document JCHPSS/94/2.

disorders and prohibiting export and import of uniodized salt. In Mexico, immunization coverage has reached 95%, no poliomyelitis case has been detected since October 1990 and measles morbidity has decreased by 97%. The National Assembly of Viet Nam had also recently raised the health and population budget for the next fiscal year from 80 million to 200 000 million dongs, and the budget for the national Programme of Action, especially targeted to meet mid-decade goals, from 2000 million to 30 000 million dongs - a 1500% increase.

25. Significant resources were being made available for the purpose by the World Bank, USAID and companies in the private sector.

26. The Executive Director of UNICEF drew attention to the unique opportunity presented by the World Summit for Social Development in March 1995, to be attended by many heads of State, where WHO and UNICEF could influence events.

27. **Recommendations.** The Committee re-emphasized the importance of the mid-decade goals both as a management tool and for the purposes of social mobilization. It recommended that:

- diseases close to eradication, those which could be solved with effective preventive and control technology and those expected to worsen because of changing demographic, social, economic and epidemiological conditions should be given priority among health problems;

- special attention should be paid to countries in greatest need (including the least developed countries, those with poorly developed health infrastructure, those in armed conflict or undergoing significant political crisis, and those new independent States with specific difficulties) and to those goals which, without accelerated support and resources, would be difficult to achieve. The necessary focus on priority problems must be achieved while avoiding separation of services for health care delivery;

- WHO and UNICEF should further strengthen the capacities of countries to achieve the end-of-decade (year 2000) goals of the World Summit for Children, concurrently with efforts to achieve the mid-decade goals, and intensify action in those areas for which goals did not yet exist, but which had a substantial impact on the achievement of the goals of the World Summit, such as those to prevent and control malaria;

- in carrying out those actions, they should focus on a holistic approach to achieve synergy between sectors for the alleviation of poverty and the achievement of good quality in care in the community.

Review of progress

(i) Expanded Programme on Immunization

28. In the introduction to the background paper,[1] reference was made to the excellent collaboration between UNICEF and WHO in support of national immunization programmes, which had also facilitated collaboration with the many other organizations in such programmes. It was epitomized by the Task Force for Child Survival and Development, which would meet shortly in New Delhi to review progress in achieving the mid-decade goals and examine the implications of the World Bank's *World development report 1993: investing in health* for the use of integrated packages of health services as a means of accelerating progress towards achieving those goals. Global coverage rates for some of the diseases covered by the Programme were static, principally as a result of substantial decreases in coverage in several African countries. A number of countries were expressing concern over supplies of vaccines for the Programme, which were insufficient to meet the demands of the disease control initiatives. Additional resources for tetanus toxoid were required for coverage of high-risk populations for neonatal tetanus; also, better identification of the populations in which all women of child-bearing age should be offered immunization against tetanus. More efforts were also required to increase the proportion of deliveries by trained and supervised birth attendants; that would require efforts over a longer term while immunization was provided against tetanus in the short term. There was a reasonable likelihood that the goal of 95% reduction in measles deaths would be met, although intensification of case management - especially the provision of vitamin A to children with measles in areas where case

[1] Document JCHPSS/94/2.1.

fatality rates were high - would be required. Remarkable progress was being made against poliomyelitis. Resources for the purchase of poliovaccine remained inadequate, however, and efforts were needed to continue to improve surveillance and to sustain high levels of coverage.

29. In Africa the sustained effort needed to ensure increasing immunization coverage up to 1990 had slackened somewhat, which may have resulted in the lesser coverage. There were, however, signs that political awareness and sustained political commitment to the goals of the Programme were returning in that region and that results would improve again. There appeared to be more general recognition of the synergy of systems and goals: each was needed to attain the other. Efforts in that direction in Africa were being pursued in the context of the Bamako Initiative. JCHP noted that the fears expressed in 1993 that vaccine prices might increase substantially had not materialized, thanks to UNICEF's work with manufacturers to stabilize prices. Collaboration with UNICEF to promote vaccine planning in countries had made good progress; a comprehensive plan had been drawn up to enable countries to forecast their vaccine needs and so reduce wastage, helping to make funding available to reach goals. The experience that gave WHO comparative advantages in quality control of vaccine production and UNICEF in vaccine procurement and supply was recognized. It was noted that there was perhaps a need to proceed from the concept of national immunization days once high coverage had been achieved - since such campaigns were very expensive to organize - and to consider how to reduce case rates more cheaply while broadening the approach to cover other aspects of the health status of children that could not be attended to in specific immunization campaigns. The Expanded Programme on Immunization should be broadened where possible in order to include other aspects of health care.

30. **Recommendations.** The Committee urged that:

- priority be given to countries where decreases in immunization coverage occurred;

- systems of vaccine production, quality control and purchase be strengthened, UNICEF and WHO intensifying their cooperation with governments to develop strategic plans to ensure adequate supplies of vaccines;

- improvements in surveillance be continued, using the EPI target diseases as models for the improvement of broader surveillance systems.

(ii) Neonatal tetanus

31. Following consideration of the background paper,[1] it was noted that the elimination of neonatal tetanus depended on the achievement of high coverage with tetanus toxoid vaccine and on ensuring clean delivery; some countries had found that very low case rates could be ensured by attention to hygiene in childbirth even without immunization. Concern was expressed that a rate below one case per thousand live births in every district of every country was not achievable by 1995 and that it was desirable to concentrate on a long-term sustainable effort; however, it was pointed out that since efforts to achieve the mid-decade goal would focus specifically on a number of limited high-risk communities not currently served by any health care system a relatively small input would achieve substantial results. Not only would the programmes help to achieve the 1995 target, they would also pave the way to providing the target communities with other health care services. The Committee recognized that monitoring progress towards the mid-decade goal would be difficult and that sustained efforts would be required to develop appropriate methods. It also recognized that using the number of pregnant women immunized as an indicator to ascertain the proportion of children protected at birth could lead to underestimation, since mothers could well have been immunized prior to pregnancy. It was further recognized that in countries where many births took place in the home a considerable reduction in neonatal tetanus could be achieved by immunizing adolescent girls of child-bearing age and involving traditional midwives in the programme.

32. **Recommendations.** The Committee recognized that the following action was required:

[1] Document JCHPSS/94/2.2.

- accelerated immunization efforts, more effective surveillance, increase in the proportion of deliveries attended by trained and supervised birth attendants; protection of at least 80% of newborn infants against neonatal tetanus; monthly reports from all districts, investigation of cases, and appropriate follow-up by the end of 1995;

- use of five-dose tetanus toxoid vaccine in countries where neonatal tetanus poses a serious public health problem; decentralized (district-based) action to ensure that health centres provide good-quality care and that birth attendants receive training, supervision and support (material);

- provision of additional resources for tetanus toxoid.

(iii) Measles deaths and cases

33. Following consideration of the background paper,[1] the Committee noted that supplementary immunization will be needed to control measles with existing vaccines. There is a need for vaccines that can be used to immunize young infants. The goal of 95% reduction in measles deaths by 1995 could be achieved with effective case management and high immunization coverage. However, this is difficult with the limitations of existing vaccines.

34. **Recommendations.** The Committee agreed that accelerated action was required to:

- increase and maintain 90% coverage with measles vaccine in children below one year of age;

- reduce mortality by using standard case management and appropriate treatment of complications;

- improve vitamin A status of young children in vitamin A-deficient areas by combined strategies including promotion of breast-feeding, dietary diversification, fortification and supplementation, and treatment of all severe cases of measles with vitamin A;

- support vaccine "research and development" to permit immunization before the age of nine months.

(iv) Poliomyelitis-free status

35. Following consideration of the background paper,[2] it was acknowledged that although high immunization coverage was the first priority in poliomyelitis eradication, vaccines should not be regarded as a panacea to rid the world of disease. Once a disease had been brought under control through immunization, integrated health services providing health care, early diagnosis, and laboratory services were needed to consolidate the gains made. In that context, the Committee noted with approval that the infrastructure for surveillance to follow up poliomyelitis eradication would be used as a platform to extend surveillance to other diseases and other indicators of health status. Attention was drawn to the fact that in some regions, such as the Eastern Mediterranean, coverage of neighbouring countries could vary widely, so that further efforts were needed to ensure adequate vaccine supplies to those with low coverage.

36. **Recommendations.** The Committee agreed that there was a crucial need to:

- mobilize resources for sufficient vaccine supply;

- improve surveillance;

- in areas targeted for poliomyelitis elimination by 1995, raise immunization coverage to 90% and sustain it with appropriate doses of oral poliovaccine in children below one year of age; paying special attention to countries or areas suffering from conflict or social unrest and where health systems are least developed, in order to achieve eradication by the year 2000.

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[1] Document JCHPSS/94/2.3.

[2] Document JCHPSS/94/2.4

(v) Oral rehydration therapy/diarrhoea case management

37. The Committee noted from the background document[1] that continued attention to oral rehydration therapy should be accompanied by appropriate "continued feeding". Further efforts were required to promote increased commitment to diarrhoeal disease control. Since the background document had been prepared, information had been received from a further six countries where the median rate of use of increased fluids and "continued feeding" was 35%. These results brought the global median to almost 25%. Significant progress was being made and further results could be expected, although it must be recognized that intensified efforts were still required to achieve the goal.

38. JCHP noted that more support was required from donor agencies and other organizations to ensure that the programme received high priority for action; USAID's very considerable contribution was noted and the hope expressed that it would be continued. Generally, accelerated and intensified efforts were required at national, regional and global levels to meet the challenge and ensure significant progress towards the mid-decade goal. It was noted that appropriate national operational strategies had been defined, taking into account specific situations within countries.

39. A need to consider increased involvement of the private sector was indicated in relation to both production and use of oral rehydration salts.

40. The role of the mass media in informing the general public about oral rehydration therapy was recognized. The Committee reaffirmed the importance of mobilizing the family and the community. Each family should be able to take first measures of control, use of oral rehydration salts should be universal at health-centre level, and - where essential drugs and, in particular, antibiotics were available - full case management should be implemented.

41. Special attention was drawn to the need to measure progress using rigorous assessment methods, in particular the methods available for household and health-facility survey, or sound adaptations of those methods.

42. The Committee reiterated the importance of effective training through carefully planned and implemented training programmes, in order to provide effective treatment of acute and persistent diarrhoea and dysentery.

43. **Recommendations**

(1) The Committee, recognizing that achievement of the mid-decade goal depends on it, urges a very significant increase in commitment of governments and supporting institutions, including international and bilateral agencies, to create a revitalized global movement involving not only the health sector but also other sectors and the public in general.

(2) JCHP recommends that such commitment should be directed to improving the skills of health workers, ensuring that health services function at a level that can assure quality of care, and achieving effective communication with families about the dangers of diarrhoea and how to respond to it.

(3) JCHP urges WHO and UNICEF to play a forceful and collaborative role to promote and support such increased commitment.

(vi) "Baby-friendly" hospitals

44. The Committee noted from the background paper[2] that all but two developing countries, one of which had had special difficulties, had taken action to end distribution of free and low-cost supplies of breast-milk substitutes and that of the 4000 hospitals targeted for achieving baby-friendly status by the end of 1995, nearly 700 had already achieved that designation.

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[1] Document JCHPSS/94/2.5.

[2] Document JCHPSS/94/2.6.

45. It was pointed out that, considering the aspirational and political dimensions of the Baby-friendly Hospital Initiative, it was doubtful that all countries would be able fully to meet the mid-decade target. Many health managers, hospital administrators and health care providers had so far failed to appreciate fully the implications and technical dimensions of the criteria for designation and, consequently, in some countries the designation had been made by national authorities even though institutions might have failed to satisfy all the criteria. The Initiative was therefore focusing on a more limited number of key institutions in the world which could be expected to have a major effect in countries as they were in the best position to act as a model for national maternity services. In addition, a category for those "committed" to achieving "baby-friendly" status had been created, with the understanding that the institutions concerned would work towards full designation. The Initiative's conceptual basis of quality of care could provide an important stimulus for the health infrastructure as a whole. It was therefore essential that the norms for the Initiative be maintained and expanded.

46. While there had been extensive progress at policy level towards ending free and low-cost supplies of breast-milk substitutes to maternity wards in hospitals, action had been somewhat confused by an apparent misinterpretation of WHO policy and the meaning of resolution WHA39.28, paragraph 2(6), which urged that small amounts of breast-milk substitutes needed for the minority of infants who require them in maternity wards and hospitals should be made available through normal procurement channels. The WHO Executive Board, at its ninety-third session in January 1994, had examined progress on the issue of supplies and concluded that free or subsidized supplies of breast-milk substitutes should not be provided to any part of the health care system, at the same time urging that extreme caution should be exercised with respect to emergency relief operations by protecting, promoting and supporting breast-feeding. The WHO Executive Board had submitted a resolution to the Forty-seventh World Health Assembly on those and other points having a bearing on the ending of supplies to maternity wards and hospitals and on the Baby-friendly Hospital Initiative. UNICEF fully endorsed the text of that resolution.

47. The need for extreme vigilance was emphasized in order to ensure that support was given to government action to end free and low-cost supplies of breast-milk substitutes at all levels in health systems. UNICEF indicated that national legislation should be the principal measure, with common agreement between the parties as a complement to the legislation.

48. The political will to ensure that the Initiative was implemented, the need for sound technical support and guidance, the requirement for additional resources to ensure sustainability of goals and to develop material for training and advocacy, mobilization at the hospital level, as well as the involvement of governments, institutions and the population in general, were all emphasized.

49. The Committee noted the importance of practical measures for increasing awareness among health personnel of the importance of informing women already during pregnancy about breast-feeding, encouraging them to breast-feed, and facilitating breast-feeding in maternity hospitals; the need to inform other members of the family of the benefits of breast-feeding; the desirability of encouraging working mothers to continue breast-feeding beyond the first months and of forming support groups for mothers; and the importance of promoting training and the development of training material. WHO and UNICEF had jointly produced such material in "Breast-feeding counselling: a training course",[1] for health workers who care for mothers and babies. Close cooperation was advocated with ILO in negotiating with trade unions to encourage employers to provide facilities in workplaces for working mothers who breast-feed.

50. **Recommendations**

(1) In order that countries might achieve the goals of the Baby-friendly Hospital Initiative, WHO and UNICEF should take steps to accelerate support in order to extend the Initiative.

(2) Steps should also be taken to ensure that all health workers receive training based on UNICEF/WHO guidelines and that appropriate training material is made available.

[1] Documents WHO/CDR/93.3-93.6 and UNICEF/NUT/93.1-93.4.

(3) With respect to the marketing of breast-milk substitutes, the establishment of, and compliance with, national regulations, administrative circulars, and other official government action should be promoted; agreements with manufacturers and distributors of breast-milk substitutes serving as a complementary measure, particularly when other interested parties are involved in obtaining such agreements (effective monitoring and enforcement is essential in any related action).

(4) The importance of government commitment and the establishment of mechanisms for the designation and reassessment of baby-friendly institutions should be reaffirmed.

(5) WHO and UNICEF should continue their support through advocacy, provision of programme guidelines, training material and global assessment criteria.

(6) Further social measures should be promoted to facilitate breast-feeding in general and beyond the initial period.

(vii) Guinea-worm transmission (dracunculiasis)

51. In the introduction to the background paper[1] it was observed that owing to political upheavals in certain countries where dracunculiasis is endemic, and to shortage of funds, the mid-decade goal to interrupt guinea-worm transmission in all affected villages by the end of 1995 would be difficult to reach. Although technically feasible, it depended on political will, social mobilization, logistic support and increased resources.

52. Although dracunculiasis was sometimes given less attention than other tropical diseases, political support for control, slow at first, had now been secured in most countries. Considerable progress had been made in social mobilization in villages where it was endemic, especially with respect to the use of drinking-water. It was important to maintain contact with local communities, which could provide sustained feedback.

53. New structures were needed for logistic support, especially operational systems for accurate surveillance and monitoring at village level, which should also involve those responsible for water supply, health and education. Emphasis was placed on certification of eradication, for which WHO was responsible. Surveillance of eradication was, however, dependent on coordination among sectors, political stability in areas under surveillance, and adequate resources and staffing. Despite reallocation of certain funds to the dracunculiasis project, a substantial shortfall still remained. The representatives of organizations of the United Nations system and other donors should be urged to focus attention on national programmes. It was also important to convince ministries of health to sustain the level of financing until the elimination of last foci. It was pointed out that UNICEF had made a major contribution to the programme and that partnership with WHO might be expanded in that area, as well as concerning additional staff.

54. **Recommendations.** The Committee recommends that the dracunculiasis eradication programme should receive support to intensify the monitoring of the status of programme interventions within endemic villages so that it is completed by mid-1994 and that control measures are initiated no later than the end of 1994, to maintain political will, to change the behaviour of local populations with respect to the use of drinking-water, and to ensure that adequate financial and staffing resources are made available.

(viii) Water supply and sanitation

55. The Committee devoted considerable attention to the costs and financing of water supply and sanitation. If the current emphasis on high-cost, high-technology water engineering was maintained, it would be impossible to achieve the goals for water supply and sanitation coverage by the year 2000. At present, only some 20% (as little as 4% in some areas) of all financial resources for water and sanitation were used for low-cost schemes in rural and urban slum areas. By using innovative low-cost methods and reallocating some financial resources, a great deal more could be achieved.

56. There was also general agreement that at the planning and implementation stages, all water supply and sanitation schemes should involve the local community which should be made responsible for maintaining the

[1] Document JCHPSS/94/2.9.

systems, where appropriate. Community schemes provided direct and tangible benefits, particularly to women, who were thus spared the task of fetching water from remote sources. The importance of involving women in the planning and management of water supply systems was noted. Experience in a number of countries, including Costa Rica and United Republic of Tanzania, showed that such an approach ensured that the water supplies would be properly used. It was necessary to ensure good quality of water supplies as well as proper access. Water safety was of paramount importance in preventing disease.

57. The Committee urged greater efforts for advocacy of various aspects of water supply and sanitation. Since the end of the International Drinking Water Supply and Sanitation Decade in 1990, other international organizations had paid little attention to the issue. Only if international organizations presented a common policy would they be able significantly to influence the policies of governments, many of which tended to focus on high-technology water supplies to well-off urban areas rather than to areas of greatest need. They must be persuaded to do otherwise. The potential benefits of high-level contacts and dialogue with heads of State on water supply and sanitation was noted.

58. In relation to Agenda-21, among the main priorities should be provision of clean water and sanitation. Some water supplies were drying up owing to deforestation and desertification. Such problems should be addressed in an overall environmental context. However, if water supplies and sanitation were regarded too exclusively as an environmental issue, as was increasingly the case following the United Nations Conference on Environment and Development in Rio de Janeiro, the health implications (e.g., typhoid and cholera epidemics) might not receive the attention their human and economic aspects merited.

59. **Recommendations**

- WHO and UNICEF should strengthen their collaboration in the joint monitoring programme (JMP) through greater resource mobilization and, at country level, capacity building;

- WHO and UNICEF should strengthen the basis of JMP for statistical purposes as well as advocacy;

- WHO and UNICEF should strengthen collaboration in education in hygiene and sanitation, focusing more on collaboration at country level;

- WHO and UNICEF should jointly support the Interagency Steering Committee on Water Supply and Sanitation (now supervising the drinking-water supply and sanitation component under Agenda-21), highlighting the mid-decade goals and calling for collaboration of all agencies in national programmes of action;

- WHO and UNICEF should support and strengthen the various regional initiatives of the Organization of African Unity (OAU), and those in South Asia, East Asia and Pacific, Latin America and the Caribbean for greater collaboration and understanding between countries in the respective regions for the achievement of the mid- and end-decade goals, and to promote regional consensus on the goal;

- WHO and UNICEF should report regularly to JCHP concerning their various initiatives and their complementary activities in the sector;

- WHO and UNICEF should support increased investment in the water supply and sanitation sector, particularly for low-cost interventions using appropriate technology in order to create a momentum to attain the end-of-decade goals;

- WHO and UNICEF should promote the operation and maintenance of low-cost sources of water in such a way as to ensure environmental protection through effective community participation.

(ix) Iodine deficiency disorders

60. In the introduction to the background paper,[1] it was reported that iodine deficiency disorders were a significant public health problem in 118 countries, where some 1571 million people lived in iodine-deficient environments, 655 million people had goitre and millions suffered mental retardation. However, the technology for prevention of such disorders was feasible, cheap and readily acceptable although it was recognized that it took some years to establish permanent, well-managed, well-monitored national iodized salt systems. The mid-decade goal related to iodine deficiency disorders was therefore realizable. Its achievement would give an accurate measurement of the degree of government commitment to and conscious political choice for health and development.

61. Some doubt was expressed that, although the goal was readily achievable, it might not be as easy to sustain. It was suggested that national plans of action on nutrition that followed up the International Conference on Nutrition (and building upon national plans of action that followed up the World Summit for Children) should include iodine deficiency disorders. Monitoring to ensure that governmental directives were being implemented would be an important aspect, since iodine concentrations in salt were very low in some countries.

62. **Recommendations.** The Committee considered that:

- action could and should be taken quickly to iodize salt in all countries where iodine deficiency disorders were a problem. The technology was feasible, relatively simple and cheap. Some countries might require assistance in purchasing equipment;

- an annual update of the iodine deficiency disorders information component of WHO's Micronutrient Data Information System should be envisaged - the cooperation of national programme managers, UNICEF and WHO Representatives was essential;

- governments should be encouraged to issue appropriate directives regarding iodization and distribution of both locally produced and imported salts;

- a good monitoring system was essential as inadequate vigilance could cause a good control programme to collapse;

- universal salt iodization would go a long way towards resolving all problems related to iodine deficiency disorders by the year 2000.

(x) Vitamin A deficiency

63. In the introduction of the background paper[2] it was reported that annually some 250 000 to 500 000 preschool children went blind from vitamin A deficiency throughout the world, and that 80 million to 90 million children in up to 75 countries could be affected by clinical or subclinical forms of vitamin A deficiency. Intervention strategies to ensure virtual elimination of vitamin A deficiency and its consequences should focus on ensuring adequate vitamin intake, using first breast-feeding and appropriate complementary feeding and continuing through dietary diversification, fortification and supplementation according to local circumstances.

64. As with iodine deficiency disorders, concern was expressed about the sustainability of achievements once targets had been met, and the need to enhance nutrition education and promote the use of appropriate locally available foods to overcome deficiencies rather than to rely primarily on additives and supplements.

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[1] Document JCHPSS/94/2.7.

[2] Document JCHPSS/94/2.8.

65. **Recommendations.** The Committee agreed that:

- strategies should be established and implemented for improving vitamin A intakes for children by 1995 and by 2000, using breast-feeding and combinations of dietary diversification, fortification and supplementation based on local circumstances;

- where clinical vitamin A deficiency is a public health problem, vitamin A supplementation for children under six years of age - with appropriate doses tailored to available contact opportunities - should be urged as a time-bound, short-term measure until dietary intakes were adequate;

- action should be enhanced by parallel strategies to control infectious diseases and parasitism. It was crucial to increase the economic status of the poor, in particular focusing on the literacy of women as reflected in the other goals of the Summit, and their ability to provide and use the food needed to overcome dietary deficiencies.

(xi) Reduction of protein-energy malnutrition

66. In the introduction of the background paper,[1] it was noted that the World Declaration and Plan of Action for Nutrition had been adopted in December 1992 by the International Conference on Nutrition. The Declaration reiterated the world community's commitment to the nutritional goals of the Fourth United Nations Development Decade and the World Summit for Children. The Plan of Action highlighted nine action-oriented themes directly relevant to meeting the needs of infants and young children which were expected to serve as guidance in the formulation of national plans of action. With additional resources and political support, the mid-decade goal to reduce malnutrition by 20% could be achieved by many countries. It was clear that UNICEF and WHO played a most important catalytic role in supporting Member States, in mobilizing resources, and in developing more effective ways to improve use of resources for implementation of strategies to reduce malnutrition. Attention was drawn to the relationship between malnutrition and disease. The potentiating effect of malnutrition on diseases had been documented. There was a need to persuade countries to make the political choice to adopt policies that would help to solve the nutrition problem.

67. In the discussion the point was made that it would be useful, in countries where change of government often meant abandonment of previously successful health policies to encourage the drawing-up of clearly defined health programmes that would withstand the negative effect of changes of government and ensure that policies were sustainable and were pursued consistently and coherently. WHO and UNICEF should assist governments in the preparation of national nutrition plans of action based on the recommendations of the International Conference on Nutrition and existing national plans of action related to the World Summit for Children. National nutrition policies should be comprehensive enough to include specific areas such as iodine deficiency disorders.

68. **Recommendations.** The Committee agreed that:

- WHO and UNICEF should support the preparation and implementation of national plans of action on nutrition, and play a catalytic role in mobilizing and proposing optimal use of resources in support of these plans;

- reduction of malnutrition was central to overall reduction of child mortality and morbidity, and that accelerated efforts were warranted.

(xii) Knowledge of HIV/AIDS-related preventive practices

69. In the introduction to the background paper (document JCHPSS/94/2.12)[2] it was stressed that WHO and UNICEF were well placed to combine their efforts to assist in supporting appropriate health and sex education so as to attain and maintain high levels of knowledge of preventive practices. WHO and UNICEF

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[1] Document JCHPSS/94/2.10.

[2] Reissued subsequent to the meeting as document JCHPSS/94/2.12 Rev.1 to reflect changes agreed upon by WHO and UNICEF secretariats.

had worked together to develop an indicator of the knowledge of adults and young people as to methods for protecting themselves from HIV infection. It was proposed to measure that indicator at mid-decade with a view to achieving the goal of 90% of young people's knowing about preventive practices by the year 2000. The two secretariats would work further on goals, particularly with regard to prevention among women, within the context of WHO's goal to achieve such knowledge among 90% of 15-to-49-year olds. The use of incidence indicators was not satisfactory, as it was impossible to establish when infection had occurred. Nor were HIV prevalence indicators of great use, since it was not possible to know whether an apparent decrease in prevalence was the result of deaths or fewer cases of infection, or a combination of both. Indirect indicators such as knowledge, condom use, number of sexual partners and care for sexually transmitted diseases were therefore more reliable.

70. The crucial need to increase knowledge among young people was recognized. Adolescent reproductive health and sexuality were a controversial and sensitive issue requiring broader dialogue with those concerned, including youth organizations and religious institutions. It was also pointed out that, in view of the numbers of young people affected, age-specific information and "life-skills education" should also be provided for the 5-to-15-year age group through schools, community organizations, family planning units, etc.

71. As HIV/AIDS had many effects undermining the family framework and affecting the health and wellbeing of children, it was important to adopt a strategic approach involving not only ministries of health but also ministries of social affairs and education. It was generally agreed that there was a crucial need to increase knowledge, particularly among young people, about HIV/AIDS.

72. **Recommendations.** As WHO's and UNICEF's expertise in their respective fields gives them a comparative advantage in advising national AIDS programmes, governments and ministries to provide or support appropriate health and sex education for all parts of society, including children in and out of school, in order to impart high levels of knowledge of preventive practices, the following activities were recommended.

73. WHO and UNICEF should achieve and maintain high levels of knowledge:

- by providing technical assistance to countries for the development, implementation and evaluation of mass communication and education programmes;

- by ensuring that at least half of the mass communication and education activities are for young people and children of all ages;

- by promoting cooperation with youth organizations in strengthening peer education, and providing technical assistance to ministries of education for the incorporation of health and sex education in school curricula;

- by collaborating with other agencies in order to introduce health education in the workplace.

IV. WORLD SUMMIT FOR CHILDREN - HEALTH INDICATORS AND THE MONITORING PROCESS

74. During the introduction of the background paper,[1] attention was drawn to the Joint WHO/UNICEF Statement on Global Monitoring of the Health Goals of the World Summit for Children, annexed to the document, and to progress and achievements. UNICEF was advising country offices to make reporting on "health for all" part of the review of country programme activities. Other matters reported included agreement by both organizations on indicators for monitoring health goals of the World Summit for Children (also annexed to the document), the preparation of guidelines to the World Summit indicators, and the proposal at the Inter-Secretariat Meeting held in October 1993 to establish a WHO/UNICEF working group on procedures for reporting progress towards mid-decade goals.

75. The two organizations were continuing close collaboration in discussions on the mid-decade goals and indicator guidelines, bearing in mind the desirability of reducing the number of indicators and the need to

[1] Document JCHPSS/94/3.

ensure that mid-decade indicators were applicable at country level. It was appreciated that the purpose of indicators was not merely to ensure data collection and measurement of progress at international level but also to strengthen national capacity to work towards the targets.

76. The importance of establishing health indicators and implementing a monitoring process was emphasized, so that progress could be measured and areas determined where further refinement of indicators was necessary, while developing awareness and ensuring mobilization of efforts from government through to community level. As an illustration of the advantages to be obtained through a system of indicators, attention was drawn to the success of the Expanded Programme on Immunization.

77. Emphasis was placed on the existing successful collaboration between the two organizations and on the challenge of extending their partnership in the further elaboration of indicators in order to ensure efficient and sustained monitoring.

78. In the ensuing discussion, considerable appreciation was expressed of the high level of collaboration between UNICEF and WHO in pursuing the World Summit goals and in developing a common approach to achieving them. Many references were made to the need to ensure that indicators were easy to use at country level and appropriate to local needs so that local health managers would be encouraged to use them in routine reporting. It was stressed that when progress towards goals was measurable and visible at local level it provided an inestimable incentive towards further progress. However, it was not realistic to expect all countries to use all indicators, since not all were appropriate to every local situation; it might be wiser for individual countries to concentrate on a limited set of indicators appropriate to their needs. In addition to capacity building and training in the use of indicators, there was therefore a need for field-testing of indicators to ensure selection of the most appropriate for individual country use. It was emphasized that the system of indicators of the Expanded Programme on Immunization, which was greatly admired, had been built up as a result of considerable effort exerted from the field level upwards. The great need in the world today was for human indicators that responded to aspirations for human development. Such indicators, through the useful feedback they provided to managers, politicians, the community and the individual, would assist in social mobilization towards achieving feasible goals. Asked whether the indicator of level of obstetric care based on number of facilities was appropriate, it was replied that it would probably be replaced by indicators of quality of care and accessibility to obstetric facilities. In response to a further question on the need for an indicator of the psychological health and development of children with respect to child abuse, the Committee was informed that a protocol on the subject was already in existence but that no funds had yet been forthcoming to finalize it. It was observed that the indicators must be understandable and feasible in all country settings.

79. **Recommendations**

- WHO and UNICEF should continue to develop comprehensive health indicators in order to achieve a sustainable health information system, priority being given to early completion of those related to the mid-decade goals (consideration should be given to countries initially applying a limited set of indicators appropriate to their needs in the interests of encouraging a flow of sustainable health information to assist national policy-making, encourage the performance of national mid-decade reviews, and promote social mobilization at all levels throughout the country);

- WHO and UNICEF should continue to improve certain indicators and measurement methods, for example, child mortality by cause;

- UNICEF should bring to the attention of all its regional and country offices the opportunities offered by national reporting on health for all to strengthen overall capacity to monitor progress at mid-decade towards the World Summit goals for children and women at country level;

- a WHO/UNICEF working group should be formed to report at mid-decade on global progress on the health goals in the World Summit Plan of Action, and to ensure that the technical programme staff of the two organizations confirmed the Summit indicators related to the mid-decade goals and to be used for global reporting; it would also strive to see that the indicator guidelines for reporting on the mid-decade goals were completed;

- an informal review meeting should be convened in 1995 immediately preceding the Inter-Secretariat Meeting to review progress on indicators and revise, if necessary, the Summit indicator table to include progress on those indicators now listed under development.

V. PLACE AND DATE OF THE THIRTIETH SESSION

80. It was agreed that the thirtieth session of the UNICEF/WHO Joint Committee on Health Policy should take place in Geneva immediately after the ninety-fifth session of the WHO Executive Board in January 1995.

VI. CONCLUDING REMARKS

81. Mr James Grant, Executive Director of UNICEF, said that periods of crisis often produced innovations; in the present critical phase of world history many governments faced cutbacks in the health sector yet were looking for new ways of moving forward. The review of the mid-decade goals had been positive, gave both organizations confidence in facing the goals for the year 2000, and would have particular relevance in the context of the forthcoming World Summit for Social Development. The Joint Committee had made an important contribution towards solving problems which involved not only the health sector but many other related sectors. Emphasizing the role played by the Committee, Mr Grant felt that it would be worthwhile exploring the possibility of holding its sessions from time to time at the UNICEF headquarters in New York.

82. Dr Hu Ching-Li, Assistant Director-General, speaking on behalf of the Director-General of WHO, thanked the Chairman for her efficient conduct of the meetings. He stressed the importance of the meeting assessing progress towards the mid-decade goals. He also welcomed the idea of possible Joint Committee sessions in New York. Mutual support was becoming increasingly important worldwide, especially in the context of forthcoming major world conferences such as the World Conference on Population and Development in 1994, the Fourth World Conference on Women in 1995, and the World Summit for Social Development in 1995. It was important that all concerned should work together so as to ensure mutually complementary goals for the year 2000 and after.

ANNEX 1

AGENDA

1. OPENING

   1.1 Election of Chairman and Rapporteurs

   1.2 Adoption of agenda and timetable — JCHPSS/94/1.1

   1.3 Statements by the Director-General of WHO and the Executive Director of UNICEF

2. WORLD SUMMIT FOR CHILDREN - MID-DECADE GOALS, 1995

   (i) **Follow-up action**
   An overview of implementation of the mid-decade goals — JCHPSS/94/2

   (ii) **Progress made**
   Progress made in specific areas, including monitoring and further actions needed to ensure the achievement of goals and targets by the mid-decade, 1995

   2.2.1 Global overview of the Expanded Programme on Immunization — JCHPSS/94/2.1

   2.2.2 Neonatal tetanus elimination — JCHPSS/94/2.2

   2.2.3 Measles deaths and cases — JCHPSS/94/2.3

   2.2.4 Poliomyelitis-free status — JCHPSS/94/2.4

   2.2.5 Oral rehydration therapy/diarrhoea case management — JCHPSS/94/2.5

   2.2.6 "Baby-friendly" hospitals — JCHPSS/94/2.6

   2.2.7 Iodine deficiency disorders — JCHPSS/94/2.7

   2.2.8 Vitamin A deficiency — JCHPSS/94/2.8

   2.2.9 Guinea-worm transmission — JCHPSS/94/2.9

   2.2.10 Reduction of protein-energy malnutrition — JCHPSS/94/2.10

   2.2.11 Water supply and sanitation — JCHPSS/94/2.11

   2.2.12 Knowledge of HIV/AIDS-related preventive practices — JCHPSS/94/2.12

3. WORLD SUMMIT FOR CHILDREN - HEALTH INDICATORS AND THE MONITORING PROCESS — JCHPSS/94/3

4. OTHER MATTERS

5. CLOSURE

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